NEW PATIENT APPLICATION

BRIDGE to HEALTH CHIROPRACTIC

Please print using black or blue ink only. If a section or question does not apply, mark N/A.

Appointment Date: | |

PATIENT INFORMATION

Last Name_____ First_____ MI_____ Age_____ Male ☐ Female ☐ Other_____

Prefered Name/Nick name_____ Date of Birth_____ SSN#_____

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Home Phone_____

Email_____ Occupation_____ Employer_____ Job Description_____

Marital Status_____ Name of Spouse_____ Kids Y/N

Who may we thank for referring you?_____

How did you hear about our office?
Facebook ☐ Our website ☐ Yelp ☐ Instagram ☐ Google Reviews ☐

_____ Other_____

HISTORY OF COMPLAINT(S)

Health Concerns	Severity (1=mild, 10=unbearable)	When did it begin?	Have you had it before, if so, when?	Is the problem from an accident or injury?	Is it consistent pain or intermittent pain?	Has your symptom...
Example: Headaches	6	1/10/15	1/15/13	Shoveling snow	Intermittent	
						☐ Improved ☐ Worsened ☐ Stayed the same
						☐ Improved ☐ Worsened ☐ Stayed the same
						☐ Improved ☐ Worsened ☐ Stayed the same

BRIDGE to HEALTH CHIROPRACTIC

Please mark the areas on the diagram to the right with the following letters to describe your symptoms.

What relieves your symptoms?_____

What makes your symptoms feel worse?_____

Is your balance/walking ability affected? If yes, explain:_____

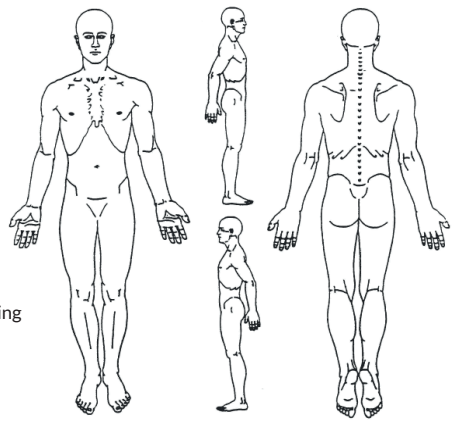
Name all doctors/therapists you have seen for these conditions and treatment you received:_____

_____

What do you think is causing your condition(s)?_____

When is it at its worst? Morning ☐ Afternoon ☐ Evening ☐

- [A] Aching
- [B] Burning
- [D] Dull
- [N] Numbness
- [R] Radiating
- [S] Sharp/Stabbing
- [T] Tingling



QUADRUPLE VISUAL ANALOG SCALE (QVAS)

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

Example:

Headache *Neck* *Low Back*

no pain 1 (2) 3 4 (5) 6 7 (8) 9 10 worst possible pain

How would you rate your pain RIGHT NOW?

no pain 1 2 3 4 5 6 7 8 9 10 worst possible pain

How would you rate your pain on AVERAGE?

no pain 1 2 3 4 5 6 7 8 9 10 worst possible pain

How would you rate your pain AT ITS BEST?

no pain 1 2 3 4 5 6 7 8 9 10 worst possible pain

How would you rate your pain AT ITS WORST?

no pain 1 2 3 4 5 6 7 8 9 10 worst possible pain

If you had to accept some level of pain after completion of treatment, what would be AN ACCEPTABLE LEVEL?

no pain 1 2 3 4 5 6 7 8 9 10 worst possible pain

ACTIVITIES OF DAILY LIVING

ACTIVITIES	EFFECT			
Carry/Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Stand Up	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Use the Computer	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Get Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit Statically	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Stand Statically	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
House/Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walk	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Wash/Bath/Shave	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes/Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Drive	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

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CHIROPRACTIC

CURRENT HEALTH PROBLEMS

Mark all that apply. This allows the doctor to have an overall view of your health status.

- ☐ Dizziness
- ☐ Headaches/Migraines
- ☐ Vertigo
- ☐ Ear Infections
- ☐ Nausea
- ☐ TMJ
- ☐ Anxiety
- ☐ Chronic Sinusitis
- ☐ Throat Issues
- ☐ Thyroid Problems
- ☐ Numbness in Arms
- ☐ Numbness in Hands
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Asthma
- ☐ Chest Pain
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Breathing Difficulty
- ☐ Ulcers
- ☐ Stomach Disorders
- ☐ Kidney Problems
- ☐ Mid-back Pain
- ☐ Gastric Reflux
- ☐ Arm/Hand Pain
- ☐ Neck Pain
- ☐ Frequent Colds/Flu
- ☐ Menstrual Disorder
- ☐ Irritable Bowel
- ☐ Sciatica
- ☐ Numbness in Legs
- ☐ Numbness in Feet
- ☐ Low Back Pain
- ☐ Bladder Problems
- ☐ Hip Pain
- ☐ Leg Pain
- ☐ Knee Pain
- ☐ Infertility
- ☐ Bedwetting
- ☐ High Cholesterol
- ☐ Menopausal Problem
- ☐ Chronic Fatigue
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ Disc Problems
- ☐ Arthritis
- ☐ Frequent Colds
- ☐ Frequent Flu
- ☐ Emotional Disorder
- ☐ Mental Disorder
- ☐ Epilepsy
- ☐ Nervousness
- ☐ Diabetes
- ☐ Leg/Foot Pain
- ☐ Other:

PAST HEALTH HISTORY

Mark any condition you have now or have had:

- ☐ Stroke
- ☐ Cancer
- ☐ Heart disease
- ☐ Spinal surgery
- ☐ Seizures
- ☐ Spinal bone fracture
- ☐ Broken bone
- ☐ Dislocation
- ☐ Cerebral vascular disease
- ☐ Scoliosis
- ☐ Diabetes
- ☐ Knocked unconscious
- ☐ Tumors
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Other:

Explain:

List all surgical operations and years:

When was your last auto accident?

Have you ever had previous chiropractic care, if so when and by whom?

Other trauma(s):

Any implant(s):

List all medication and supplements:

List all allergies/sensitivities to medication, food, and other items and their reactions:

SOCIAL HEALTH HISTORY

Smoking: ☐ Cigars ☐ Pipe ☐ Cigarettes

Alcohol consumption:	☐ Daily	☐ Weekends	☐ Occasionally	☐ Never
Recreational drug usage:	☐ Daily	☐ Weekends	☐ Occasionally	☐ Never

Hobbies, Recreational Activities, Exercise Regimen:

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FAMILY HEALTH HISTORY

Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No

If yes whom? ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Children

Have they ever been treated for their condition? ☐ Yes ☐ No ☐ I don't know

Any other hereditary conditions the doctor should be aware of? ☐ Yes ☐ No

PATIENT QUALITY OF LIFE SURVEY

Please take several minutes to answer these questions so we can help you get better.
(Please mark all that apply)

How have you taken care of your health in the past?	☐ Medications ☐ Emergency Room ☐ Routine Medical	☐ Exercise ☐ Nutrition/Diet ☐ Holistic Care	☐ Vitamins ☐ Chiropractic ☐ Other
How did the previous method(s) work out for you?	☐ Bad results ☐ Some results ☐ Great results	☐ Nothing changed ☐ Did not get worse ☐ Did not work very long	☐ Still trying ☐ Confused
How have others been affected by your health condition(s)?	☐ No one is affected ☐ Haven't noticed any problem ☐ They tell me to do something	☐ People avoid me	
What are you afraid this might be (or beginning) to affect (or will affect)?	☐ Job ☐ Kids ☐ Future ability	☐ Marriage ☐ Self-esteem ☐ Sleep	☐ Time ☐ Finances ☐ Freedom
Are there health condition(s) you are afraid this might turn into?	☐ Family health problems ☐ Heart disease ☐ Cancer	☐ Diabetes ☐ Arthritis ☐ Fibromyalgia	☐ Depression ☐ Chronic Fatigue ☐ Need surgery
How has your health condition(s) affected your job, relationship, finances, family, or other activities? Please give examples			
What has that cost you (time, money, happiness, freedom, sleep, promotion, etc)? Please give examples			
What are you most concerned with regarding your condition(s)?			
Where do you picture yourself being in the next 1-3 years if this condition(s) is not taken care of? Please be specific			
What would be different/ better without this condition(s)? Please be specific			
What do you desire most from working with us?			
What would that mean to you?			

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INFORMED CONSENT

Regarding Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

When I meet with the doctor, I will be advised how chiropractic, like all forms of healthcare, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and exceptionally rare, minor fractures, and possible stroke, which occurs at a rate of one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Bridge to Health Chiropractic will be explained to me until I convey understanding and consent to all recommended treatment means, techniques, and methods by the Bridge to Health doctor team.

Patient or Authorized Person's Signature	Date	Witness Initials

Regarding X-Rays/Imaging Studies

By my signature below I am acknowledging the hazardous effects of ionization to an unborn child. I am conveying my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have a diagnostic x-ray examination in the event that the doctor deems it necessary in my case.

Patient or Authorized Person's Signature	Date	Witness Initials

FEMALES ONLY

Please read carefully and initial the boxes.

☐ The first day of my last menstrual cycle was on _____ Date

☐ To the best of my knowledge I am not pregnant.

INSURANCE AUTHORIZATION

I hereby authorize payment to be made directly to Bridge to Health Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Bridge to Health Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature	Date Completed

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, bylaw, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. I understand that this information can and will be used to:

1. Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.
4. Emergency - in the event of a medical emergency we may notify a family member
5. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprise you of
6. changes in practice hours or upcoming events.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICE containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose, to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Patient or Authorized Person's Signature	Date Completed	Doctor's Signature	Date Form Reviewed